TREATING PSYCHOLOGICAL TRAUMA AND PTSD

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THE GUILFORD PRESS
New York London

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Case History Analysis of the Treatments for PTSD: Lessons Learned

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This book casts a broad net over the field of trauma therapy. In this chapter, we attempt a synthesis through the more narrow view of the case histories in this book. What can we glean from the clinical work of experts in the field that may inform us about the indications for and the limitations of the various approaches? How do core approaches work differently to affect posttraumatic stress disorder (PTSD) and its allostatic forms? How can core approaches work in a complementary or sequential way?

In the concluding section of this chapter we look at the same case histories to examine common underlying features among the core approaches: Are there similar ways in which patients feel improved? Are there common ways in which clinicians work?

We return to the tetrahedral model of PTSD presented in Chapter 2, reviewing it in the light of specific clinical cases. In doing so we place the core approaches in relationship with each other: What is unique about each method? How do the interventions of the different modes work? How does entry into the complex world of PTSD through one portal lead the patient and clinician to discover other aspects of the disorder? How do the different approaches work together, either adjunctively or sequentially?

The 27 case histories reported in this book, *in toto*, do not form a representative or random sample on which we can test hypotheses, nor does our data easily lend itself to a definitive meta-analysis. But they do provide rich illustrations which teach us how practitioners of the differing core approaches think about their patients and what it is in their approach that works. Further, because we asked therapists to fill in certain uniform details about the traumas of their patients, the details of interventions that mattered most, and the presenting symptoms, we seek here to uncover patterns among treatment choices which may warrant further research.

Often, proponents of the various approaches at this point in our history seek to expand the usefulness of their approach to a wider scope and wider range of patients with PTSD. But emphasizing only the widening scope of each modality gives little help to the clinician trying at a given moment in time to determine the best fit between his or her patient and the various approaches.

CASES REPORTED

The book contains 27 case histories (which are summarized in Appendix 15.1 at the end of this chapter), as follows: psychopharmacological treatment, cases 23 and 24; psychoanalytic/psychodynamic therapy, cases 14–20; cognitive-behavioral therapy, cases 21 and 22; constructivist therapy, cases 4 and 5; dual diagnosis, case 25; culturally specific treatment, cases 1–3; family and couple therapy, cases 9–13; and groups therapy, cases 6–8.

MATCH BETWEEN TREATMENT APPROACH AND ACCESS TO PTSD CORE PHENOMENOLOGY

In Chapter 2 (Figures 2.2 and 2.3), we presented a tetrahedral model of core PTSD phenomenology and its relation to ego states and object relations. This provides five portals through which differing treatment approaches can meaningfully engage the core issues for the client with PTSD: P-1 engages the client around object relations, attachment, intimacy, and interpersonal relations; P-2 engages the client in response to symptoms of hyperarousal and physiological reactivity; P-3 engages the client's avoidance, detachment, and numbing; P-4 engages the client's altered ego states, self-structure, and identity configuration; and P-5 engages the client in areas of intrusion and reexperiencing.

The clinical presentations which therapists first engage their clients with PTSD, that is, the portal through which treatment begins, varies to some degree with the core approach. For those clients who entered treatment in

hopes of altering disturbed patterns in interpersonal relations (P-1), especially intimacy and attachment (cases 4, 5, 6, 9, 10, 11, 13 and 20), therapists used group, family and individual psychodynamic and constructivist approaches. For example, Sam (case 6), a Vietnam war veteran fearing his tendency to sabotage relationships, homicidal revenge fantasies, and experience of any affect as being out of control, would damage his relation with his child, chose the group setting to obtain help. While his pathology contained multiple traumas and pathology amenable to different core approaches, his presenting difficulty matched best with the group approach.

When clients presented with symptoms of hyperarousal and physiological reactivity (P-2), as in cases 1, 2, 14, and 24, the therapist was apt to prescribe medication when using the psychobiological approach alone or in conjunction with either psychodynamic psychotherapy or culturally specific treatment. For example, DG (case 24), coincident with the pain and physical debilitation in adulthood, developed traumatic nightmares and startle/hypervigilant reactions of earlier childhood abuse. While earlier antidepressants had not helped, his psychiatrist prescribed beta-blockers to assist the allostatic load on the adrenergic system. Medication helped hyperarousal in other settings as well. For example, Phong (case 2), a 64-year-old Vietnamese man, sought help for nightmares, headaches, insomnia, and isolation. Phong was a war veteran and former officer; he had been held prisoner for 12 years in Vietnam by the communists. His wife and children were killed in the same war. His therapist, part of a culturally specific setting, was well suited to offer Phong immediate attention to his physiological hyperactivity with medication and cultural support through P-2.

In case histories (cases 7, 12, 18, and 25) where engagement with the client was primarily through P-3 (symptoms of avoidance, detachment, and numbing), the therapists employed group, family, individual psychodynamic, and dual diagnosis modes. For example, an American veteran of the Vietnam War (case 12) whose worst trauma in Vietnam occurred at Christmas time, withdrew into his room or "bunker" rather than be with his family during the holiday. The family felt shut out at just the most important time to be making contact. At his family's urging he was able to engage family therapy as a core approach well suited for presenting problems of P-3. There, his therapist engaged the family's dilemma with most meaningful results.

The clients who presented with altered ego states and self-structure were treated in a culturally specific setting, and by individual therapists offering constructivist, psychodynamic, and dissociative identity disorder approaches (cases 3, 4, 19, and 26). For example, Ms. A (case 4), a woman traumatized in childhood by parental neglect, abuse by a neighbor, and sexual abuse by a priest presented with a threatened sexual identity and difficulty in relationships, especially trust. Her sense of herself was as vulnerable and unsafe, and in response she was hypercritical of others to compensate for low self-esteem.

The constructivist approach engaged her presenting problems and her complex PTSD as well. For Mihai (case 19), whose symptoms of guilt, shame and nightmares grew worse as right-wing views gained renewed strength after the recent revolutions in Romania, his central issue revolved around the integrity of his identity. Memories returned of his imprisonment as a 20-year-old for his political views, when he was tortured, forced to torture others, and brainwashed during the Stalin era. His therapist was able to use a psychodynamic approach to engage him around the central issue of retaining one's self under overwhelming pressure to yield.

When the portal through which the patient presented was the reexperiencing and intrusion dimension of the disorder (P-5: cases 15, 16, 17, 21, 22, and 23) the approach was cognitive-behavioral engagement, one of the psychodynamic therapies, and medication. Those who, after some trust building, were able to narrate their trauma in a reasonably coherent script were well suited for the cognitive-behavioral approach. For example, Alice (case 21) complained of recurrent intrusive images of her being assaulted and raped with its possible consequences (fear of HIV), nightmares, avoidance of public places and transportation, and all contact with strangers. She was irritable, hypervigilant, and depressed. Her cognitive-behavioral therapist was well equipped to engage her reexperiencing symptoms through an imaging plan and dosed behavioral techniques, well suited for P-5.

On the other hand, those patients whose initial presentation was of reenactments which could not be described by the patient and which could only be clinically inferred tended toward the psychoanalytic approach. For example, Tina (case 17) presented with trauma-related somatic re-enactments (seizure-like movements repeating her 8-year-old son's movements before his death). She was unable at that time to verbalize a coherent story of the trauma history. Her psychodynamic therapist provided great relief when he was able to translate her seizure-like behavior into meaningful expressions of her grief and trauma. The psychoanalytic approach was well suited for the patient unable to verbalize her reexperiencing phenomenon (P-5).

Rarely were the portals unidimensional. Once one aspect of the disorder was engaged, often others would be as well. For example, a client having engaged around hyperarousal or numbing might move on to address interpersonal relations. Or, having first engaged problems in intimacy, the treatment would go on to uncover the impact of reexperiencing on those relationships and on the self-structure. Where the core treatment engaged reexperiencing, it invariably also addressed hyperarousal and avoidance as well. For example, in the case just mentioned of Tina, after work on the somatic reenactments of her son's death, she revealed a lifelong pattern of masochistic relationships. Exploring this interpersonal dimension of her life in turn led to memories of detachment and numbing, and finally to a new set of childhood traumas involving incest from her father and retaliatory enemas from her mother. With the recovery of these memories came new symptoms

of dissociation and fragmented self-states. An allostatic adaptation to the childhood sequence emerged where she retained sanity only through a fantasy of her angel-like goodness shielding her from her pain.

With regard to the portals of entry, the core approaches form clusters. Regarding P-1 (interpersonal symptoms) the psychodynamic therapies—individual, group, and family dynamic therapies—engage easily. This same grouping of therapies can engage detachment and avoidance. Physiological hyperarousal (P-2) is the province of psychobiology. Often hyperarousal is also connected to reexperiencing symptoms (P-5). When these symptoms are related to a specific trauma memory, the cognitive-behavioral approach fits, and when the memories are indistinct, individual psychodynamic treatment is the choice. Finally, where it is damaged self-structure (P-4) which is the presenting condition, constructivist and analytic approaches engage best.

Culturally specific settings attend to highly traumatized patients with multiple traumas, so physiological hyperarousal (P-2) and damaged self-structure (P-4) are prominent portals of entry.

RECOVERY ENVIRONMENT, OUTREACH, AND REFERRAL

Implicit in the case histories is the importance of specific sensitivity to a given trauma by the clinician and by the service setting itself. Survivors of natural disaster, for example, may find themselves in service settings which are not attuned to trauma. For example, the initial psychiatric diagnosis of Clyde, a 22-year-old man with depression, failed to uncover the presence of PTSD case 25 (dual diagnosis). In fact, he was treated unsuccessfully with electroconvulsive therapy (ECT). Later, in a PTSD-sensitive environment, history was obtained that his friends and their family were incinerated in a bushfire when he was age 8. In fact, he was experiencing intrusive images of a bushfire endangering his current city and his family home, and the diagnosis of PTSD had been missed.

The above case also illustrates a point of outreach. It is important to remember that the delivery of professional mental health care to the traumatized survivor is a relatively new phenomenon. Not long ago, PTSD patients were described as a "reluctant population" (Lindy, Grace, & Green, 1981) and outreach was considered indispensable to the success of any therapeutic effort. Among the cases presented by expert therapists in this book, we find that community outreach is practiced in each of the public, private, and academic settings in which the therapist contributors work. Indeed, without it, many of the clients whose treatments are described in this book might not have had access to a PTSD-sensitive environment. This is particularly true in the cross-cultural settings for traumatized Asian American immigrants and those refugees seeking political asylum.

SOURCE OF REFERRAL

The search for help often comes first from someone living with the PTSD patient rather than from the patient him- or herself. Given a reluctance to recognize or face the origins of the problems, some of our clients or patients find themselves able to accept the idea of treatment only when accompanied by others whom they trust. We were interested to see which core approaches matched with these referral patterns. Clients entering group, family, and couples therapy were often assigned to this approach in response to the pain and difficulties which other family members were having in relating to them. For example, Sam (case 6), a combat veteran with PTSD, presented with intrusive and numbing symptoms, family problems, and alcohol and self-medication problems. In Vietnam he had been ambushed, saw his buddy killed in front of him, engaged in body counts, and witnessed many deaths of civilians. With a history of aversive responses to other treatments, his main focus was on his family problems as he was attempting to rejoin his wife and daughter.

In contrast to the above, individual psychodynamic therapies and cognitive-behavioral therapies were more likely to be on the basis of referral from another professional. Constructivist therapies were self-referrals. Medication occurred in all categories of referral, as medication was frequently a complementary treatment approach.

REFERRALS OF INDIRECT PTSD

Sometimes it is in the indirect survivor, the family member or friend of the traumatized person, who has developed symptoms and seeks help for him- or herself. We were interested in which approach seemed to adapt best to these circumstances.

In two cases, the identified patient was not the traumatized survivor but his indirectly traumatized child. In both of these instances it was the family therapy setting which was attentive to the multigenerational impact of trauma. For example, a 4-year-old child (case 10) presented in her nursery school with oppositional behavior, tantrums, separation anxiety, and nightmares. The parents learned that the child was searching for her father's missing eye which he lost in Vietnam, although this had never been discussed in the family. The family therapist provided an ideal setting in which the father could explain to his daughter the emotional pain of the loss of his eye in an explosion during the war, and also explain that he was getting the help he needed for that pain. The daughter felt reassured that her perceptions about her father were correct (he had been having an anniversary reaction to the loss) and that he could still be a whole giving father even without his eye.

CHARACTERISTICS OF THE TRAUMA EXPERIENCE

In the following subsections, we examine characteristics of the traumatic events themselves and their match with core approaches. In doing so we peruse the case studies for patterns in the characteristics of the trauma, its acuteness or chronicity, its repetitiveness, its location, the presence of concomitant loss, and the roles and identifications of the survivor within the trauma context.

Trauma Population

Among our case histories, war veterans who experienced their trauma in a small-unit context tended to match with the group approach. Incest survivors who experienced their trauma in the home tended to match with individual constructivist or psychodynamic approaches. Victims of a well-defined episode of civilian violence or rape matched with the cognitive behavioral approach. Survivors of natural disasters are reported in dual diagnosis, cognitive-behavioral therapy, and among the psychodynamic cases. Of course there is much overlap as well. In fact, many expert clinicians chose cases to demonstrate the widening scope of the validity of their approach. A patient with early childhood trauma was successfully treated with medication, and another through group work, whereas war veterans without early childhood trauma were among those treated successfully by analytic therapists. Nonetheless, the overall tendencies are worth noting.

Acuteness versus Chronicity of Trauma Response

Experts in most core approaches chose to illustrate their points with cases where trauma occurred between 10 and 25 years ago. In contrast, experts in the cognitive-behavioral approach chose cases within the past year or so.

Single versus Repetitive and Brief versus Prolonged Trauma

The cases selected by authors of chapters representing the various core approaches divide sharply on the issue of chronicity.

In 21 cases, trauma was multiple and prolonged; in 3 cases, trauma was single and relatively brief. In either category, the traumas were severe. For example, Ven (case 1, a culturally specific treatment setting), a Cambodian refugee of the Pol Pot (Khmer Rouge) terror, is widowed and experienced her son's decapitation and the death by starvation of two children through the Khmer Rouge political terror. Of the single events, one was an assault/rape, the second a shooting in the abdomen. The 21 multiple and

prolonged traumas were treated by the full spectrum of core approaches save for cognitive-behavioral therapy; those in the single-event category were treated only with the cognitive-behavioral approach.

Isolated Individual Trauma versus Community Trauma

In the majority of cases, trauma occurred to the client in a community context such as political persecution, war, or natural disaster. Those who experienced trauma in a community context tended to be treated in a community context, that is, culturally specific settings or by group and family approaches, settings in which similarly impacted survivors can express thoughts and feelings.

On the other hand, a little more than one-third received their traumas in isolated settings, without a community of similarly traumatized survivors. In many of the cases in this isolated category, the perpetrator of trauma was an emotionally significant person in the survivor's life, as in child abuse or incest. Among those cases where the trauma occurred in isolation, treatments were more likely in an individual context by constructivists, analytic therapists, or cognitive-behavioral therapists.

In isolated traumas, the perpetrator was most often a person whom the victim knew and toward whom he or she had intensely ambivalent feelings. These clients were treated by therapists using the constructivist and psychodynamic approaches, both of which engage the nuances of interpersonal relations and damaged self-states. The constructivist therapies in particular focused on empowering the client to form healthier, stronger boundaries (i.e., the intrapsychic site of the trauma in these particular cases; see the *Modes of Therapeutic Action* section below for case illustrations).

Loss and Delayed Grief

Significant loss (death of family members or close friends) is often part of the trauma experience, especially for children. Indeed, two-thirds of the case histories reported in this book record loss as part of the picture. In nine cases, the loss was striking—such as being forced to watch a husband being decapitated, or seeing one's best friend killed, or a child witnessing her mother's murder by a boyfriend.

Of those patients with striking losses, delayed grief became a focus of work in the analytic therapies. Of those where the striking loss was addressed in nonspecific supportive terms, the patients were seen in culturally specific settings.

Of note are two cases where the death was primarily the result of the patient's own action, that is, the patient was in the role of perpetrator. These were seen in dynamic treatments—one individual (see case 18 below) and one group.

Trauma Role

Symptoms of the clients in all of the approaches related back to their experiences of being overwhelmed in the trauma situation. Where the specifics of these trauma memories are recalled in depth, it is most often in the role of victim. But some occupied primarily other roles such as rescuer, supporter, or perpetrator.

While most patients' symptoms make sense as a result of their own experience in the trauma situation, some through unconscious identification with another in the trauma situation make sense only in light of the second person's trauma experience. For example, a 2-year-old boy simply played with the curls in his hair, attempting to visualize his mother's pretty hair when in fact he was responding to images of her bloodied hair after she was shot in the head in front of him. In case 18, Abraham's symptoms of loss also took a bodily form. This Vietnam veteran, father of a 13-year-old boy, carried himself hunched over with a somber visage as though he carried the living dead. In dynamic psychotherapy, his therapist finally learned that this striking posture contained Abraham's delusion that another 13-year-old boy, the one whom he had shot in a free-fire zone but held in his arms while dying, was still alive on his shoulder, influencing his current life.

The Trauma Experience Remembered Clearly versus Indistinctly

In constructivist and psychodynamic approaches, therapists do not require patients to have conscious knowledge of the details of trauma experiences before the work itself can begin. The therapist assumes that the client may be unaware of a certain trauma either through unconscious repression or through disavowal, where details of the trauma may be hidden via strong affects such as shame or guilt. In children, levels of cognitive and emotional development will affect the child's ability to use words. In some of these therapies, the capacity to tell the story of the trauma is a treatment goal in and of itself. In contrast, cognitive-behavioral treatment protocols, imaging or exposure, require narration of the trauma as a starting point.

DEMOGRAPHIC FACTORS IN THE HISTORY ANALYSIS

Race

A disturbing pattern regarding race emerges. Most case illustrations where race is mentioned involve whites, except where a culturally specific treatment program has been established. Therapists are mostly also white. While these numbers by no means capture the state of affairs in our field, they do indi-

cate a pattern which we, as clinicians, need to be more sensitive to and find new solutions for. We know that there is great need to find and demonstrate suitable approaches to nonwhite trauma clients in the general population, and we need nonwhite therapists to join in carrying them out.

Sex

There are several noteworthy patterns regarding sex in the match between therapists and clients in the differing core approaches. Constructivist therapists, mostly women, treated women assaulted mostly by adult men, whereas group therapists, mostly men, treated male war veterans who were exposed to trauma at the hands of mostly enemy men as young adults and adolescents. The affinity generally seems to be toward a therapist and therapeutic setting of the same sex as the client. Two of three cases reported in which the clinician ran into difficulty as the treatment itself began to feel unsafe were situations where the male therapists were treating women whose perpetrators had been men.

Marital Status

Half of the clients are married, and distribution between married, and unmarried clients among the approaches appears even. It is worth noting that two of three clients in the culturally specific settings are widowed as part of the trauma experience itself, having lost their spouses in the political terror which caused their own PTSD. It is curious that completed analytically treated patients are more often married, perhaps suggesting that spousal support may be an ingredient in sustaining this treatment.

Age

In terms of the age of traumatization, specialists in child trauma of course provided the right fit for children, although some children with indirect PTSD appeared within the family treatment context. Among those who are now adults but whose trauma occurred in early childhood, both constructivist and psychodynamic approaches seemed to fit well.

MODES OF THERAPEUTIC ACTION

In the following subsections we use the case histories to identify unique modes of action of the core approaches and to see if we can find reasonable hypotheses for the tendencies discussed above which tend to match different trauma circumstances with different core approaches.

From the vantage point of the therapist, experts in the different ap-

proaches hypothesize differently about the aspect of the disorder that is being engaged and how the therapist's understanding and interventions lead to change in that engaged segment of the whole.

Cognitive-Behavioral Approaches

Cognitive-behavioral therapists attend to the intrusive effects of reexperiencing and provide practical means of extinguishing these phenomena. They provide a way for clients to frame and reframe the narrative of their traumatic experiences. The clinician proceeds on the basis that desensitization to traumatic stimuli attenuate those stimuli, restoring a pretraumatic equilibrium, both psychologically and physiologically. They reduce target symptoms of PTSD by habituating reexperiencing phenomena both within the safety of the therapeutic space and in environments which evoke pathological reactions. This improves the survivor's available energy to invest in healthy relationships and in self-development. The task both during the therapy sessions and in assignments at home is to overcome avoidance of traumatic memory by challenges that are specific, modulated, and of sufficient duration to achieve attenuation. For example, Alice (case 21) experienced unbidden thoughts and images as well as nightmares of her experience of being assaulted in an alleyway, robbed, and raped vaginally and anally. She was preoccupied with fears of HIV infection and could not enter public places or contact strangers. After mastering deep breathing exercises, she developed with her counselor a series of *in vivo* exercises from least difficult to most difficult. Her counselor encouraged her to tell the story of her rape, record it, and listen to the recording. Anxiety measured highest as she became aware of rage that she could contract HIV from the event. The counselor encouraged her to focus on fear rather than anger to get over this hurdle in imaginal listening. The treatment led to a vast reduction in PTSD symptoms in nine visits.

Group Therapy

The group therapist finds that the alienation of the trauma survivor is most directly engaged by members of a similarly traumatized yet recovering peer group. Group members offer the client a uniquely effective means of engagement. The group offers acceptance, empathy, support, and useful suggestions regarding adaptation. The therapist and cotherapist as well as other group members educate the client regarding the nature of PTSD. The group provides immediate feedback on ways in which pathology affects others. For example, Sam (case 6), a Vietnam war veteran, entered group therapy fearing that his lethality and self-loathing would destroy his effort to rejoin his wife and child. He found that the group members' understanding ("Family know how to push your button") and empathy (having been through similar experiences) enabled them to accept his feelings and fears. They were also practi-

cally helpful, getting him back to Alcoholics Anonymous (AA) and coming up with alternative strategies for dealing with hypervigilance.

Also, some dynamic groups address irrational expectations of the therapists as in transference and countertransference. Here again, group members can normalize and underline idiosyncracies regarding expectations of its members in this regard.

Constructivist Self-Developmental Theory

The constructivist therapist is careful to assess the patient's sense of self and bases the effect of the treatment on ways in which the therapeutic relationship bears on this sense of self. Since violation of boundaries is central in the traumas of childhood in complex PTSD (e.g., abuse, incest), it is only reasonable that the boundary between the client and the therapist becomes loaded, the site around which change may occur. This takes place when the patient can accept and verbalize wishes and when the therapist can appropriately—yet flexibly—negotiate new solutions. This enables new schemas to take hold. For example, Ms. C. (case 5), overwhelmed by a paranoid mother as a child and a traumatizing husband as an adult, felt that the 45-minute session did not meet her needs. Together with her therapist, she renegotiated this boundary of the therapy frame and altered it to 90 minutes per session, demonstrating her power to influence a boundary in a way which better met her needs.

Psychodynamic Approaches

For the analytic therapist, understanding, mastery, and meaning are core objectives which match the patient's needs regarding impaired relationships and a damaged sense of self. These are as much the focus of the therapeutic work as are manifest symptoms. It is the nature of the repetition compulsion that the important aspects of the trauma, conscious and unconscious, will tend to repeat themselves in the therapeutic space. Much of the memories so obtained will be new to the patient's awareness. As this occurs, it is the relationship, through the managing of the frame with interpretation, which is the site of therapeutic action. This is true in maintaining healthy aspects of the relationship in the therapeutic alliance as well as in the interpretation of its irrational components (as in transference, countertransference, and enactments). The here and now of the therapeutic setting, after the patient experiences it as safe enough, gains all the intensity of the trauma itself and includes the defensive operations which the patient has unconsciously used to cope with the trauma's effects. Reflection, interpretation, and empathy are crucial to the success of this method. Education and medication are often complementary. The task of monitoring countertransference is immense; the consequences of not monitoring it may derail a treatment, and finding the right balance is always important. For example, with Mihai (case 19, discussed ear-

lier) empathically appreciating his need to yield while being brainwashed by Stalinist torturers could only be understood and communicated after the therapist was able to recognize by self-analysis that same tendency to yield existed in himself. In the case of Annette (case 16), the therapist was unaware of a countertransference in which he was the therapeutically overzealous mother. Annette's presenting symptom was her excessive preoccupation with the bowel habits of her 3-year-old child. She had repressed her own memory of being traumatized as a child by her mother's terrifying enemas (motivated by her mother's fear that Annette would develop the fatal illness of her sibling). All this came to light when her therapist commented that they would have to "go deeper" and responded to her anxiety by getting the patient a glass of water. Hearing the faucet, Annette dissociated, writhing on the floor as if being administered an enema. Later, understanding and translating (reconstructing) the traumatic enemas of childhood was possible when the therapist discovered that, through his therapeutic zeal, he had become, in the transference, the traumatizing mother. Discovering and working through her own trauma memories helped Annette with the current fears regarding her children and permitted the reworking of a number of key relationships.

Treatment of Families and Couples

For the family/couples therapist, especially useful is the capacity for the therapist to create a climate where family members can elucidate the ways in which PTSD interferes with intimacy. The couples therapist works to find creative ways to restore intimacy through genuine empathy and reciprocity once both parties understand the suffering of the other. The family therapist diagnoses problems in marital and family dysfunction such as enmeshment, boundary problems, or interference with intimacy, educates family members about the disorder of PTSD, and assists them (including the client) to reframe their impasse in terms of a dialectic dilemma in empathic terms, capable of creative solutions rather than a deadlock. For example, a Vietnam combat veteran (case 12), whose worst trauma in Vietnam occurred at Christmas time, withdrew into his room or "bunker" rather than be with his family during the holiday. The family felt shut out at just the most important time to be making contact. In family therapy, the therapist helped the family reframe this dialectic dilemma into a need to do something together which honored servicemen at that time of year. They successfully evolved a plan to serve a soup kitchen as a family.

Psychopharmacological Approaches to Cross-Cultural Treatment

Sometimes, the totality of losses, traumas, and dislocations in traumatized persons who have been political refugees is hard to imagine. The combined

approach which uses support by medication, socialization, and cultural resonance, while keeping a safe distance from activating more trauma than the patient can endure to remember, is most effective. For example, Christina (case 3), a 25-year-old widowed graduate student, was struggling with suicidal thoughts, not eating or sleeping, and unable to find anything in life which stirred hope. She had experienced multiple traumas in an African civil war. Her husband was decapitated; she was raped, their home burned, and her parents presumed killed, although their bodies had not been found. Her therapist was able to engage her damaged sense of self and hopelessness (P-4) by participating in her advocacy for political asylum within a culturally specific setting.

Uncovering, Suppressing, and Coping with Trauma Memory

The modes of therapy for PTSD fall along a spectrum as regards the stated value of suppressing versus uncovering trauma memory. Several therapeutic approaches focus on suppressive techniques. Medication, for example, suppresses hyperalert neurohormonal systems, reducing the frequency and impact of intrusive memory. Supportive groups are designed, via group acceptance, education, support, and centrality of daily living, suppress trauma memory; culturally specific trauma settings, as in case 3 of Christina (just discussed), employ medication and support within a culturally consonant setting which suppresses trauma memory. We see the same in work with the severely mentally ill. Therapists using the cognitive-behavioral approach emphasize the uncovering of the traumatic memory so that with cognitive and behavioral exercises it can become attenuated. Psychodynamic approaches strive for a balance between trauma narration, when the patient is ready, and suppression of traumatic memory when such memory, disrupts ego function. Constructivists work gradually and in the present so that new schemas can replace old ones; psychoanalytic therapists let daily occurrences be the clues that old traumas still organize new events, so that insight, empathic self-understanding, and internalization of function can restore altered intrapsychic systems; and family therapists attend to the trauma itself only insofar as dialectic dilemmas may be confronted and reframed in the here and now rather than avoided. The balance between expressive and suppressive techniques in a given case is often a delicate one, and the sensitive therapist utilizing any approach may at times chose aspects of either. For example, selective serotonin reuptake inhibitors (SSRIs) may allow trauma memory to emerge with clarity. Analytic therapists may reinforce defenses in order to dose the emerging of trauma memory. Cognitive-behavioral therapists may substitute a more tolerable supportive/suppressive affect such as fear for the disruptive potential of rage (see case 21, Alice) so that a procedure can continue rather than be disrupted. Indeed the timing of sup-

pressive versus uncovering or expressive aspects of treatment is an art in many of the approaches described.

The Voice of Change

Within a given approach, change occurs when the clients feel that they now possesses knowledge or mastery which they did not earlier possess. What is the new source, voice, or perspective which traumatized clients are able to internalize as authentic and therefore enables them to change, and what is it about PTSD that makes this perspective so authentic?

1. *Group therapy.* Because the subjective experience of trauma is beyond understanding in the usual sense, peers who have undergone the same or similar trauma may be heard by the survivor as a truly authentic voice whereas others may not. In the group treatment cases, it is the observations by other group members which seem to have the greatest valence.
2. *Family therapy.* The isolation and alienation which often accompany PTSD drives away those who care most about the client. In contrast to experts, it may be one's own family member (e.g., a child) who may break through barriers in ways others cannot—say, to clarify the need for treatment or to empathize with the suffering from PTSD.
3. *Cognitive-behavioral therapy.* Here the client's own trauma descriptions, literally his or her own voice on tape, stirs affect and new memory. Also, newly experienced physiological mastery carries strong authentic weight.
4. *Analytic and constructivist therapies.* The internalized voice of analytic therapists gains authenticity as they pass the patients' unconscious tests of them and as they use transference, countertransference, and reenactment constructively to forward mastery and healing. The process for constructivist therapies is similar.
5. *Psychopharmacological therapy.* For patients collaborating with their physicians in finding the right psychopharmacological intervention, the patients feel empowered when their expertise in describing their situation is matched by the clinicians' expertise in finding the right medication and dosage.

Ultimately, in all the approaches it is each client's acceptance of his or her own voice which mitigates change. We emphasize here that the site of recovery from the psychological effects of trauma is not our office, our words, or the words of others in our settings, nor our prescriptions, behaviors, or technologies. Rather, the site of recovery is within the biopsychosocial space of the survivor. By locating recovery in the survivor rather than in our technique, we can see that various core approaches may offer assistance at specific points in time in the course of the disorder and its recovery. Even in the same survivor, approaches may assist recovery at certain times by support-

ive/suppressive means and at other times by expressive means. Alternatively our approaches may harm recovery when we apply the wrong method at the wrong time. In the end, we strive like our clients not only to remove symptoms but to restore those healthy psychological functions and adaptive biological systems which have been damaged subsequent to the trauma.

IMPORTANCE OF THE RELATIONSHIP WITH THE THERAPIST

While all modes depend upon the generally benign and hopeful presence of an expert/authority, there are some approaches where this is the exclusive realm of the relationship: (1) in culturally specific trauma settings, the doctor/leader occupies a wise-man role familiar to the villagers of Southeast Asia; (2) in cognitive-behavioral therapy, in the supportive–suppressive groups and in the use of medication, there are efforts to sustain the positive benign authority and to interfere with tendencies to the contrary as resistances to the treatment.

Several modalities utilize the relationship with the therapist to convey more than the positive general alliance; indeed, they use specific irrational components projected on to the therapist as an avenue for further work on the trauma itself. Psychoanalytic constructivist and dynamic family/group therapies follow these precepts. The understanding and use of such transference phenomena differ somewhat among the approaches. Constructivists offer a new object relationship around which core issues can be more healthfully negotiated. Through a growing regard for self, the clients recognize and express their needs and the therapists within the constraints of their role negotiate a response which goes a significant distance toward meeting those needs. In group and family settings, trusted individuals can point out the irrational nature of transference reactions which the client is having; they can point out the nature and effects of trauma reliving on the client and on those close to him or her. The psychoanalytic perspective offers the widest use of transference phenomena, as in this approach the relationship is key to healing.

COMMONALITIES AMONG THE APPROACHES

While the foregoing discussion has noted distinguishing features in the core approaches, we are left with the conclusion that they have many features in common. All of the core approaches seek to have the patient claim "authority over traumatic memories" (Herman, 1992). All approaches seek to reduce symptoms, to improve function, to improve relationships, to achieve better understanding of oneself, and to promote a more positive appraisal of self and the world.

While technical efforts to achieve these ends with the core approaches involve differences, they share the many nonspecific aspects of the treatment relationship which include listening, empathy, structure, and dosage. The relationship must be caring, respectful, and uncompromisingly ethical. In the end, all approaches embrace the notion of self-empowerment and mastery.

Similarities in Process: Safety, Disclosure, and Reconnection

To a remarkable extent all the approaches concern themselves whether overtly or covertly with the three phases of treatment, variously called (1) safety, building the alliance, trust, and relaxation training; (2) disclosure, trauma narrative, trauma script, and imaginal exposure; and (3) reconnection, self-continuity and meaning, integration, and synthesis.

A Few Purists

Among the experts writing chapters in this book, there are few who are not open to the valid addition of techniques which have historically been associated with other core approaches. Those who rely primarily on pharmacotherapy attend to the dynamics of the working alliance; psychodynamic therapists utilize cognitive reframing and medication; behaviorists use cognitive techniques; group clinicians make transference interpretations; clinicians treating patients with dual (or triple) diagnosis may prescribe medication and utilize cognitive-behavioral and psychodynamic therapies in the same patient. Indeed, the climate of the field has been such as to encourage the sharing of knowledge among experts for the common good of the trauma survivor.

Common Difficulties

In the cases described in this book, therapists using cognitive-behavioral, psychopharmacological, constructivist, and psychoanalytic approaches all identified difficult moments in their cases. In each instance the patient at least temporarily experienced loss of safety and control within the treatment. For example, one client felt unsafe and refused to return after her cognitive-behavioral therapist prolonged an *in vivo* exposure by staying with the client in a dark closet longer than the patient feared was tolerable. In one case a psychoanalytic therapist, urging the patient to go deeper, precipitated a troubling reenactment. In one constructivist case the patient momentarily felt unsafe when the therapist refused to answer a personal question regarding her sexual orientation. The psychopharmacologist identified the contradictory impact of psychological and neurophysiological aspects of the same case such that the same medications were safe during the day but unsafe at night.

One group therapist conveyed concern that the termination process for one group member might risk reexposure to an unsafe world without the support of the group. In all the above cases, the client had moved at least temporarily from a more safe to a less safe state. The means of addressing these temporary periods of loss of safety vary with the different approaches.

SUMMARY

From the case histories in this book we infer certain patterns of practice among expert trauma clinicians that provide clues to the relative indications for and limitations of the core approaches to PTSD. The cognitive-behavioral approach is especially useful if the portal of entry is a reexperiencing of a defined traumatic memory, such as rape or violence, which is capable of being put into words. It is also especially useful when the trauma is a single event and relatively recent, and when the client's role is that of victim. The approach is salient in such cases because the client directly confronts those fears which cause the symptoms and, by attenuating them, gains mastery over them.

The constructivist approach engages interpersonal and self-state aspects of the client's current and past life. This approach addresses itself to patients with complex PTSD who are victims of childhood abuse, often sexual. Their memories are often indistinct at first, and the perpetrator is someone about whom the client has strongly ambivalent feelings. The trauma has occurred in an isolated setting with profound effects on current life and relationships. The treatment directly engages schemas of self-esteem, and the therapist provides a healthy model in both regulation of self-esteem and management of boundaries, so that intimate relations may develop with hope and trust rather than suspicion.

The psychodynamic spectrum of approaches (individual, family, and group) respond well to clients who present with avoidance/detachment, interpersonal problems, and damaged self-states. Traumas include war, torture, incest, and natural disaster. Traumas are usually multiple, include significant losses, and have occurred some years in the past. Dynamic treatments are particularly suited when the patient is experiencing guilt regarding his or her role as the perceived perpetrator or when symptoms of reexperiencing represent the suffering of others in the trauma situation.

The psychopharmacological approach is well suited for patients who present with symptoms of physiological hyperarousal and the reexperiencing symptoms of PTSD. It may work well in conjunction with all other approaches. It is particularly recommended in culturally specific settings, the severely mentally ill, and dual (or triple) diagnosis.

The group approach highlights opportunities to work on interpersonal aspects of trauma, detachment, alienation, avoidance, and loss. In this book,

patients discussed were largely war veterans, although any community of trauma survivors is well suited for this modality. Groups rebuild acceptance in self and trust in others where trauma has disrupted it.

The family approach like others in the dynamic cluster appeals to patients with interpersonal and avoidance/detachment presentation. Family members rather than the person with PTSD may mobilize the treatment. It is a setting well designed to reestablish communication where trauma has wrought breaks in intimate relations. Further, the setting is well suited for family members who themselves suffer PTSD indirectly from their affected relative.

Of course, the patterns we describe here come from the limited database of the case histories in this book and the experience of the editors. In our view, these clinical patterns are of practical use for the reader of this book and deserve the attention of researchers in the future to test them rigorously.

Thoughtful clinicians who wish to avail their patients of the best possible fit between the presenting situation (both overt symptoms and the interpersonal and intrapsychic difficulties) and the core treatments available need to take a careful history, elaborate the presenting symptoms, and inquire sensitively about the nature of the trauma as the client is now able to describe it. Such efforts will put clinicians in a position to make good use of the final two chapters of this book.

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APPENDIX 15.1

Name	Age	Demographics	Symptoms	Trauma and loss	No. of years Posttrauma	Medications	Treatment forms	Status
Cross-Cultural:								
Case 1								
Ven (Ch. 11)	49	Female Widowed Cambodian refugee	Trouble sleeping Trembling Pain Bilateral numbness Chronic	One son decapitated Two children starved Husband killed and legs cut off	23	Doxepin Clonidine Fluoxetine	Socialization groups	Improved Vulnerable
Case 2								
Phong (Ch. 11)	64	Male Single Vietnam refugee Colonel	Headaches Trouble sleeping Nightmares Alone Chronic	Political prisoner, 12 years Wife and children killed	? 7	Fluoxetine Trazodone Clonidine	Socialization groups	Partial improvement
Case 3								
Christina (Ch. 11)	25	Female Widowed Zaire refugee Student	Poor sleep Poor appetite No enjoyment in life Suicidal ideas Subacute	Husband decapitated Parents presumed killed Raped Home burned	?	Imipramine Clonidine Propranolol	Individual support Psychotherapy Religious community support Political asylum	Improved
Complex PTSD								
Case 4								
Ms. A (Ch. 9)	45	Female Married Professional	Dissociated Not in tune Relation difficulty Threatened identity Chronic	Parental neglect Child abuse by neighbor Child abuse by priest, ages 4–6	> 30		Individual long-term psychotherapy	Improved

Case 5								
Ms. C (Ch. 9)	40s	Female Divorced	Depressed, alone Unsatisfied in relations Unsatisfied in work Chronic	Mother's paranoid illness Abusive relationship with husband, 20 years	> 5	None	Individual long-term psychotherapy	Improved
Case 6								
Sam (Ch. 8)	50	Male Remarried, twice Veteran	Unable to parent Sabotaged relationships Feared loss of control Anger, numbness, alcohol	Abused by mother's boyfriend Abandoned by father Abusive foster home Vietnam firefights Wounded with shrapnel Chronic	> 25		Group treatment Dynamic	Improved
Case 7								
John (Ch. 8)	50	Male Married Veteran	Isolated Self-destructive alcohol use Unable to get anything out of life	Atrocities Horrific death of best friend		?	Family therapy	Family improved John is questionable
Group, cognitive-behavioral								
Case 8								
Mark	48	Male Divorced Veteran	Disagreement with supervisor Discomfort around others	Explosion which injured friends Heavy combat Nightmares	25	?	Group cognitive-behavioral	Improved
Family/couples								

Case 9: Family where father avoids 13-year-old girl having killed child that same age in Vietnam (Ch. 13)

Case 10: 4-year-old child is searching for father's missing eye from Vietnam (Ch. 13)

Case 11: Mother of combat veteran depressed and guilty for hospitalizing homicidal son (Ch. 13)

Case 12: Combat veteran and wife "living separate lives" because PTSD not understood (Ch. 13)

Case 13: Couple unable to connect; depressed at anniversary of friend's death (Ch. 13)

(*continued*)

APPENDIX 15.1 *cont.*

Name	Age	Demographics	Symptoms	Trauma and loss	No. of years Posttrauma	Medications	Treatment forms	Status
PTSD and SMI								
No cases								
Psychoanalytic								
Case 14								
Frank (Ch. 5)	50	Male Married Veteran	Fatigue Unable to rest	Reconnaissance Search-and-destroy missions		On medications	Analytic	Improved
Case 15								
Rob (Ch. 5)	50	Male Married Veteran	Impulsive Suspicious Nightmares	Scout		On medications	Analytic	Improved
Case 16								
Annette (Ch. 5)	35	Female Married Work at home	Impaired parenting Anxiety	Traumatic enemas as a child		None	Analytic	Improved
Case 17								
Tina (Ch. 5)	Mid-40s	Female married Counselor	Somatic reenactment Masochistic relationships Suicidal	Death of child Incest as child		Fluoxetine	Analytic	Mild improvement
Case 18								
Abraham (Ch. 5)	37	Male Married Veteran	Numbness Alienation Blocked emotions with son	Search and destroy missions Killed Vietnamese boy and grandfather		Imipramine	Analytic	Improved

Case 19								
Mihai (Ch. 5)	69	Male Married Political prisoner	Guilt Shame Nightmares	Brainwashing Imprisonment Torture		Analytic	Improved	
Case 20								
Kelly (Ch. 9)	48	Female Married Counselor	Cut off from feelings	Childhood physical abuse Childhood sexual abuse		None	Analytic	Some improvement
Cognitive-behavioral								
Case 21								
Alice (Ch. 7)	58	Female Divorced African/ American Real estate agent	Intrusive thoughts Nightmares Trouble sleeping Intense physical/emotional reactions	Robbed Raped vaginally and anally	1		Cognitive-behavioral	Improved
Case 22								
Rebecca (Ch. 7)	34	Female Single Restaurant manager	Recurrent thoughts Nightmares Intense physical/emotional responses Unable to work/drive by restaurant	Shot Stalked	6 months		Cognitive-behavioral	No change
Psychopharmacology								
Case 23								
KM (Ch. 4)	42	Female Executive	Dissociative episodes	Childhood sexual abuse	> 30	Clonidine Guanfacine	Pharmacological	Improved

(*continued*)

APPENDIX 15.1 *cont.*

Name	Age	Demographics	Symptoms	Trauma and loss	No. of years Posttrauma	Medications	Treatment forms	Status
Case 24								
DG (Ch. 4)	55	Male Disabled	Nightmares Startle reactions	Childhood sexual abuse Childhood physical abuse Problems with intimacy	> 30	Beta-blocker	Pharmacological	Partial improvement
Case 25								
Clyde (Ch. 10)	Early 20s	Male Student	Depression Intrusive images	Bushfire	14	Monoamine oxidase inhibitor	Cognitive-behavioral Analytic	Improved